DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 7

2. STATE: Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
* 42 CFR 440.40

7. FEDERAL BUDGET IMPACT: See Attachment
a. FFY 2000 $ 8,433,370
b. FFY 2001 $ ~~20,087,976~~ 19,829,317

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 572 - The amendment establishes procedures for providers to obtain additional funds for increased staffing for registered nurses, licensed vocational nurses, medication aides, and nurses aides in nursing facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded to you when received.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
6/9/00 6-12-00

16. RETURN TO:
Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 14, 2000

18. DATE APPROVED:
June 29, 2000

19. EFFECTIVE DATE OF APPROVED MATERIAL:
May 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:
* Pen & ink change made per State's telefax request.

FORM HCFA-179 (07-92)

Instructions on Back

Attachment to HCFA-179 for
Transmittal No. 00-07, Amendment No. 572

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-D	Attachment 4.19-D
Page 3a	Page 3a (TN 96-18)
Page 4	Page 4 (TN 96-18)
Page 4a	Page 4a (TN 92-02)
Page 4a1	Page 4a1 (TN 90-33)
Page 4a2	New
Page 4a3	New
Page 4a4	New
Page 4b	Page 4b (TN 96-04)
Page 6	New
Page 6a	New
Page 6b	New
Page 6c	New
~~Page 6c-1~~	~~New~~ - deleted in 10/26/00 revisions
Page 6d	New
Page 6e	New
Page 6f	New
Page 6g	New
Page 6h	New

(C) Adjustments to certain reported expenses. TDHS makes adjustments to the expenses reported by providers to ensure that expenses used in rate determination are required for long term care, derived from the market place and incurred from economic and efficient use of resources.

(1) Limits on certain administration costs. To ensure that the results of cost analyses accurately reflect the costs that an economic and efficient provider must incur, related-party facility administrator and owner salaries, wages, and/or benefits are limited to the 90th percentile of nonrelated-party administrator salaries, wages and/or benefits adjusted for inflation using the Personal Consumption Expenditures (PCE) chain-type price index. Related-party assistant administrator salaries, wages, and/or benefits are limited to the 90th percentile of nonrelated-party assistant administrator salaries, wages, and/or benefits adjusted for inflation using the PCE chain-type price index.

(2) Occupancy adjustments. TDHS adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. The target occupancy rate is the lower of (a) 85 percent or (b) the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost-reporting periods included in the rate base. For each provider whose occupancy falls below the target occupancy rate, an adjustment factor is calculated as follows: adjustment factor = 1.00 - (provider's occupancy rate / appropriate target occupancy rate). This adjustment factor is then multiplied by each cost line item in the facility and administration cost areas of the cost reports, and the result of this calculation is subtracted from the line item amount.

(D) Projected Costs: TDHS determines reasonable methods for projecting each provider's costs to allow for significant changes in cost-related conditions anticipated to occur between the historical cost-reporting period and the prospective rate period. Significant conditions include, but are not limited to, wage-and-price inflation ~~or~~ deflation, changes in program utilization and occupancy, modification of federal or state regulations and statutes, and implementation of federal or state court orders and settlement agreements.

(1) General Cost Inflation Index. TDHS uses the PCE chain-type price index as the general cost inflation index. The PCE chain-type price index is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective reimbursement period, TDHS uses the lowest feasible PCE chain-type price index forecast consistent with the forecasts of nationally recognized sources available to TDHS at the time proposed reimbursement is prepared for public dissemination and comment.

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SUPERSEDES: TN • 96-18

(IV) Rate Setting Methodology.

(A) Case-mix classes. Texas Department of Human Services' (TDHS) reimbursement rates vary according to the assessed characteristics of recipients. Rates are determined for 11 case-mix classes of service, plus a twelfth, temporary classification assigned by default when assessment data are incomplete or in error.

(B) Reimbursement determination.

(1) Rate components. Under the case mix methodology, rates are comprised of five cost-related components: the dietary component; the general/administration component; the fixed capital asset use fee component; the other recipient care component; and the direct care staff component. The direct care staff component is calculated as specified in (VI).

(a) The dietary component is constant across all case-mix classes.

(i) For rates effective May 1, 2000, using the inflation factors used in determination of the nursing facility rates in effect January 1, 2000, project the costs in the 1998 Texas Nursing Facility Cost Report database to the rate period beginning January 1, 2000, and ending August 31, 2000. Using these projected costs, determine the median per diem dietary cost (weighted by Medicaid days of service in the database) in the array of allowable per diem costs for all contracted nursing facilities included in the January 1, 2000 database, multiplied by 1.07.

(ii) For rates effective September 1, 2000, multiply the dietary per diem rate from (IV)(B)(1)(a)(i) by 1.016, which is the lowest feasible rate of increase for the PCE chain-type price index from the January through August 2000 rate period to the prospective rate period of state fiscal year (SFY) 2001.

(iii) For rates effective September 1, 2001, and thereafter, the dietary component is calculated at the median cost (weighted by Medicaid days of service in the database) in the array of projected allowable per diem costs for all contracted nursing facilities included in the applicable database, multiplied by 1.07.

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(b) The general/administration component is constant across all case-mix classes.

(i) For rates effective May 1, 2000, the general/administration rate component is equal to the difference between the general, administration, and dietary rate component in effect January 1, 2000, and the dietary rate component as calculated in (IV)(B)(1)(a)(i).

(ii) For rates effective September 1, 2000, multiply the general/administration per diem rate from (IV)(B)(1)(b)(i) by 1.016, which is the lowest feasible rate of increase for the PCE chain-type price index from the January through August 2000 rate period to the prospective rate period of SFY 2001.

(iii) For rates effective September 1, 2001, and thereafter, the general/administration component is calculated at the median cost (weighted by Medicaid days of service in the database) in the array of projected allowable per diem costs for all contracted nursing facilities included in the applicable database, multiplied by 1.07.

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SUPERSEDES: TN 92-02

(c) The fixed capital asset use fee component is calculated as follows:

(i) Determine the eightieth percentile in the array of allowable appraised property values per licensed bed, including land and improvements. Appraised values for this purpose are determined by the most recent appraisal available from the local taxing authority and reported on the Texas Medicaid cost report. Tax-exempt facilities not provided an appraisal from their local taxing authority because of an exempt status must contract with an independent appraiser to appraise the facility land and improvements. Facilities not reporting an appraised property value are not included in the array for purposes of calculating the use fee.

(ii) Project the eightieth percentile of appraised property values per bed by one-half the forecasted increase in the Personal Consumption Expenditures (PCE) chain-type price index from the cost-reporting year to the rate year.

(iii) Calculate an annual use fee per bed as the projected eightieth percentile of appraised property values per bed times an annual use rate of fourteen percent.

(iv) Calculate a per diem use fee per bed by dividing the annual use fee per bed by annual days of service per bed at the higher of 85 percent occupancy, or the statewide average occupancy rate during the cost-reporting period.

(v) The use fee is limited to the lesser of (a) the fee as calculated in (IV)(B)(1)(c)(i)-(iv) above, or (b) the fee as calculated by inflating the fee from the previous rate period by the forecasted change in the PCE chain-type price index.

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SUPERSEDES: TN • 98-33

(d) The other recipient care rate component varies according to case-mix class of service.

(i) For rates effective May 1, 2000, using the inflation factors used in determination of the nursing facility rates in effect January 1, 2000, project the costs in the 1998 Texas Nursing Facility Cost Report database to the rate period beginning January 1, 2000, and ending August 31, 2000. Using these projected costs, determine the sum of other recipient care costs in all nursing facilities included in the 1998 database. Then divide the total by the sum of recipient days of service in all facilities in the 1998 database. Multiply the resulting weighted, average per diem cost of other recipient care by 1.07. The result is the average other recipient care rate component. To calculate the other recipient care per diem rate component for each of the 11 TILE case-mix groups and for the default group, multiply each of the standardized statewide case-mix indexes used in the determination of the nursing facility rates in effect January 1, 2000 by the average other recipient care rate component.

(ii) For rates effective September 1, 2000, multiply the average other recipient care per diem rate from (IV)(B)(1)(d)(i) by 1.016, which is the lowest feasible rate of increase for the PCE chain-type price index from the January through August 2000 rate period to the prospective rate period of SFY 2001. To calculate the other recipient care per diem rate component for each of the 11 TILE case-mix groups and for the default group, multiply each of the standardized statewide case-mix indexes used in determination of the nursing facility rates in effect January 1, 2000, by the average other recipient care rate component.

(iii) For rates effective September 1, 2001, and thereafter, the average other recipient care rate component is calculated as follows. Adjust the raw sum of other recipient care costs in all nursing facilities included in the applicable database in order to account for disallowed costs and inflation, as specified under (III). Then divide the adjusted total by the sum of recipient days of service in all facilities in the database. Multiply the resulting weighted, average per diem cost of other recipient care by 1.07. The result is the average other recipient care rate component. To calculate the other recipient care per diem rate component for each of the 11 TILE case-mix groups and for the default group, multiply each of the standardized statewide case-mix indexes from (IV)(B)(3)(b) below by the average other recipient care rate component.

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(2) Case-mix classification system. All Medicaid recipients are classified according to the Texas Index for Level of Effort (TILE) classification system. The TILE classification system includes four clinical categories, which are further subdivided on the basis of an Activity of Daily Living (ADL) scale, resulting in a total of 11 TILE case-mix groups. A twelfth group is used by default when a recipient's case-mix group membership is indeterminate because of assessment errors or omissions. The default group is paid at the lowest case-mix rate until TILE assessment data are available in the payment system. Each of the eleven case-mix groups is assigned a case-mix index of effort. This index reflects the relative amount of direct and indirect care time, on average, devoted by direct care personnel to recipients in each group.

(3) Standardized statewide case-mix indexes. Staff determine standardized statewide case-mix indexes according to the following procedures:

(a) Determine the statewide average case-mix index for all Medicaid recipients, except those in the default group. Weight the indexes from (IV)(B)(2) above, which are based on a sample of nursing facilities, by estimated statewide recipient days of service by case mix group during the cost reporting period covered by the database. The statewide average index is based on the most recent and complete data available indicating recipient days of service by case-mix group which correspond to the period covered by the cost reports included in the applicable database.

(b) Calculate standardized statewide case-mix indexes. Determine the standardized statewide case-mix index for each of the 11 TILE groups by dividing each of the indexes described under (IV)(B)(2) above by the statewide average case-mix index described under (IV)(B)(3)(a).

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(4) Total case mix per diem rates. Total case mix per diem rates vary according to case mix class of service and according to participant status in the Enhanced Direct Care Staff Rate described in (VI).

(i) For each participating facility, for each of the 11 TILE case mix groups and for the default group, the recommended total per diem rate is the sum of the following five rate components:

(I) the dietary rate component from (IV)(B)(1)(a);

(II) the general/administration rate component from (IV)(B)(1)(b);

(III) the fixed capital asset use fee component from (IV)(B)(1)(c);

(IV) the case mix group's other recipient care per diem rate component by case mix group from (IV)(B)(1)(d); and

(V) the case mix group's total direct care staff rate component for that participating facility as determined in (VI)(F).

(ii) For nonparticipating facilities, for each of the 11 TILE case mix groups and for the default group, the recommended total per diem rate is the sum of the following five rate components:

(I) the dietary rate component from (IV)(B)(1)(a);

(II) the general/administration rate component from (IV)(B)(1)(b);

(III) the fixed capital asset use fee component from (IV)(B)(1)(c);

(IV) the case mix group's other recipient care per diem rate component by case mix group from (IV)(B)(1)(d); and

(V) the case mix group's total direct care staff rate component for nonparticipants as determined in (VI)(E).

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(5) Supplemental reimbursement for ventilator-dependent residents. Qualifying residents receive a supplement to the per diem rate specified in (IV)(B)(4) above.

(i) To qualify for supplemental reimbursement, a resident must require artificial ventilation for at least 6 consecutive hours daily and the use must be prescribed by a licensed physician.

(ii) A ventilator-dependent resource differential case-mix index is calculated, based on time-study research data. This resource differential index reflects the difference between direct nursing services for ventilator-dependent residents and services for residents in the most severe heavy-care TILE group.

(I) The per diem rate supplement for participants in the Enhanced Direct Care Staff Rate described in (VI) is calculated by multiplying the resource differential case mix index times the per diem average other recipient care rate component, as described in (IV)(B)(1)(d) and by the average direct care staff rate component for participating facilities staffing at the minimum levels required for participation as described in (VI)(F) and summing the products.

(II) The per diem rate supplement for nonparticipants in the Enhanced Direct Care Staff Rate described in (VI) is calculated by multiplying the resource differential case mix index times the per diem average other recipient care rate component, as described in (IV)(B)(1)(d) and by the average direct care staff rate component for nonparticipants as described in (VI)(E) and summing the products.

(iii) The supplemental reimbursement for residents requiring continuous artificial ventilation is 100% of the per diem ventilator rate supplement.

(iv) The supplemental reimbursement for residents not requiring continuous artificial ventilation daily but requiring artificial ventilation for at least 6 consecutive hours daily is 40% of the per diem ventilator rate.

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(VI) Enhanced Direct Care Staff Rate.

(A) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), Medication Aides, and nurse aides performing nursing-related duties for Medicaid-contracted beds.

(B) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year. An implementation rate period will begin on May 1, 2000, and end on August 31, 2000.

(C) Enrollment. Each contracted facility must notify the Texas Department Human Services (TDHS) of its desire to participate or its desire not to participate in the Enhanced Direct Care Staff Rate and its desired level of participation by submitting an enrollment contract amendment during the enrollment period. Implementation enrollment began on April 1, 2000, and ended on April 14, 2000. Standard enrollment begins on the first day of July and ends on the last day of that same July preceding the standard rate year for which payments are being determined. Should conditions warrant, additional enrollment periods may be conducted during a rate year.

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(D) Determination of staffing requirements for participants. Facilities choosing to participate in the Enhanced Direct Care Staff Rate agree to maintain certain direct care staffing levels. In order to permit facilities the flexibility to substitute RN, LVN and aide (Medication Aide and nurse aide) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN equivalent minutes. The most recent available, reliable relative compensation levels for RNs, LVNs and aides in Texas NFs, including salaries, wages, payroll taxes and benefits, are used to convert RN and aide minutes into LVN equivalent minutes. For example, if the most recent available, reliable relative compensation levels for RNs, LVNs, and aides were $0.42, $0.28, and $0.14 per minute respectively, one minute of LVN time would be equivalent to 0.67 minutes of RN time ($0.28 / $0.42 = 0.67), and to two minutes of aide time ($0.28 / $0.14 = 2.00). Conversely, one minute of RN time would be equivalent to 1.5 minutes of LVN time ($0.42 / $0.28 = 1.5), and one minute of aide time would be equivalent to 0.5 minutes of LVN time ($0.14 / $0.28 = 0.5).

(1) Minimum staffing levels. For each participating facility, determine a minimum LVN equivalent staffing level as follows.

(a) Determine minimum required LVN equivalent minutes per resident day of service for various types of residents using time study data, cost report information, and other appropriate data sources.

(i) Determine LVN equivalent minutes associated with Medicare residents based on the data sources from (D)(1)(a) adjusted for estimated acuity differences between Medicare and Medicaid residents.

(ii) Determine minimum required LVN equivalent minutes per resident day of service associated with each Texas Index for Level of Effort (TILE) case mix group and additional minimum required minutes for residents reimbursed under the TILE system who also qualify for supplemental reimbursement for ventilator care or pediatric tracheostomy care. These minimum required minutes are determined using the data sources from (D)(1)(a) adjusted for acuity differences between Medicare and Medicaid residents and other factors.

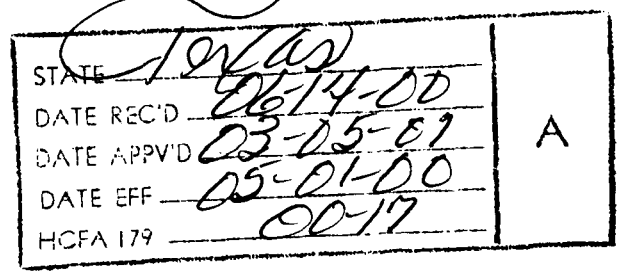
(b) Based on most recently available, reliable utilization data, determine for each facility the total days of service by TILE group, days of service provided to TILE residents qualifying for Medicaid supplemental reimbursement for ventilator or tracheostomy care, total days of service for Medicare Part A residents, and total days of service for all other residents.

(c) Multiply the minimum required LVN equivalent minutes for each TILE group and supplemental TILE reimbursement group from (D)(1)(a) by the facility's Medicaid days of service in each TILE group and supplemental TILE reimbursement group from (D)(1)(b) and sum the products.

(d) Multiply the minimum required LVN equivalent minutes for Medicare residents by the facility's Medicare Part A days of service.

(e) Divide the sum from (D)(1)(c) by the facility's total Medicaid days of service, with a day of service for a Medicaid TILE recipient who also qualifies for a supplemental TILE reimbursement counted as one day of service, and multiply the result by the facility's other resident days of service.

(f) Sum the results of (D)(1)(c), (d), and (e), divide the sum by the facility's total days of service, with a day of service for a Medicaid TILE recipient who also qualifies for a supplemental TILE reimbursement counted as one day of service. The result of these calculations is the minimum LVN equivalent minutes per resident day the participating facility must provide.



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